6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	**Example 2**
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

H. Recapture of depreciation resulting from sale of assets.

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement, indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to facilities prior to reimbursement under the FRVS shall be determined as follows:

   (a) The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the

accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 1/3 year depreciation recapture phaseout schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sales price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000
Older Portion of facility:
Number of beds =60
Newer portion of facility:
Number of beds =120
Allocation to older portion: (60/180) x 6,000,000 = $2,000,000
Allocation to new portion: (120/180) x 6,000,000 = $4,000,000
Sale Price $6,000,000

(b) The adjusted gross recapture amounts as determined in (a) above shall be allocated for fiscal periods from January 1, 1972, through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(c) The net recapture overpayment amount, if any, so determined in (b) above shall be paid by the former owners to the State. If the net recapture amount is not paid by the former owner, in total or part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation recapture resulting from leasing facility or withdrawing from Medicaid program. In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Medicaid provider. After April 1, 1983, all owner-providers that

withdraw from the Medicaid program shall be required to sign a contract with the Agency creating an equitable lien on the owner's nursing home assets. This lien shall be filed by the Agency with the clerk of the Circuit Court in the Judicial Circuit within which the nursing home is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the Agency upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid program, the reduction in the gross depreciation recapture amount calculated in Section III. H.1. (a) above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients. EXAMPLE: An owner-operator participates in Medicaid for 60 months. He then withdraws from the Medicaid program and leases the facility to a new operator, who enters the Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Medicaid program and operates the facility for another 5 years, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be (60+24 - 48) months times 1.00 percent. If a provider fails to sign and return the contract to the Agency, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method.

1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the facility.

2. Upon sale of assets recapture of reimbursement due to indexing under FRVS shall be determined as follows:

   (a) The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the facility has been reimbursed under FRVS;

   (b) For months 61 and subsequent, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the facility had Medicaid utilization greater than 55 percent for a majority of the months that the facility was reimbursed under FRVS; and

3. Documented costs of replacement equipment purchased subsequent to FRVS payments and for which additional payments were not made per Section V.E.1.j. shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity.

A reasonable return on equity (ROE) for capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the principles stated in Chapter 12, CMS-PUB.15-1 except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Medicaid Program.

ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full return on equity payment shall be calculated on 20 percent of the FRVS asset valuation per Section V.E. 1.e. of this plan and included in the FRVS rate.

K. Use Allowance.

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in Chapter 12, CMS-PUB.15-1 established in Section J. above, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including governmentally owned or operated facilities, all provisions of J. above, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.

L. Legal Fees and Related Costs.

In order to be considered an allowable cost of a provider in the Florida Medicaid Program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the

successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If, on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal, as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA, relating to Medicaid audits, Medicaid cost reimbursement cases, including administrative rules, administrative rules affecting Medicaid policy, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. Effective January 1, 2002, the direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. Direct care staff does not include nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

N. Effective January 1, 2002, all other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company for staff who do not deliver care directly to residents in the nursing home facility.

Providers on budget at the January 1, 2002 rate setting will not be required to submit a supplemental schedule. The Agency for Health Care Administration will divide the

interim patient care costs into direct and indirect subcomponents based on a 65% and 35% split, respectively. The patient care split will be subject to settlement upon receipt of their initial cost report.

IV. Standards

A. In accordance with Section 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. For purposes of establishing reimbursement ceilings, each nursing home within the State shall be classified into one of six reimbursement classes as defined in V. A.3 of this plan. Separate reimbursement ceilings shall be established for each class. Separate operating and patient care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January 1 and July 1. Prior to July 1, 2004, the most current cost reports postmarked or accepted by a common carrier by October 31 and April 30 and received by November 15 and May 15, respectively, shall be used to establish the operating and patient care class ceilings. Beginning July 1, 2004, cost reports with periods ending June 30, 2004 or after, received at AHCA, Bureau of Medicaid Program Analysis, Audit Services by the close of the business day on October 31 and April 30, or by the close of the next business day if October 31 or April 30 fall on a weekend, shall be used to establish the operating and patient care class ceilings. Beginning with the January 1, 1988, rate period additional ceilings based on the Target Rate System shall also be imposed. Beginning with the July 1, 1991 rate period, additional ceilings for new providers shall also be imposed. The

first cost report submissions for all newly constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end of these newly constructed facilities shall be after October 1, 1977. In addition, all facilities with year ends prior to that of the one hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceilings. Ceilings shall be set at a level, which the State determines to be adequate to reimburse the allowable and reasonable costs of an economically and efficiently operated facility. The property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan pending transition to payments based on the FRVS shall be the ceiling in effect at July 1, 1985. The operating and patient care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating and patient care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates. A provider shall be exempt from the operating and patient care class ceilings and target rate ceilings if all of the following criteria are satisfied:

a) All of the resident population are dually diagnosed with medical and psychiatric conditions.

b) No less than 90 percent of the resident population suffers from at least one of the following: severe behavioral, emotional, or cognitive difficulties resulting from their psychiatric impairment.

c) The facility provides clinically appropriate care to address these behavioral, cognitive, and emotional deficits.

d) A medically approved individual treatment plan is developed and implemented for each patient. The plan comprehensively addresses the

client's medical, psychiatric, and psychosocial needs.

e) The facility complies with the licensure provisions for specialty psychiatric hospitals in accordance with Rule 59A-3 FAC.

f) The facility complies with HRSR 95-3 with regard to psychotropic drugs or establish written facility standards that meet or exceed this regulation.

g) The facility complies with HRSM 180-1 with regard to quality assurance procedures or establishes written facility standards that meet or exceed this regulation.

Beginning on or after January 1, 1984, provider whose reimbursement rates are limited to the class ceiling for operating and patient care costs shall have their reimbursement exceeded under the circumstances described below. The provider must demonstrate to the Agency that unique medical care requirements exist which requires extraordinary outlays of funds causing the provider to exceed the class ceilings. Circumstances which shall require such an outlay of funds causing a provider to exceed the class ceilings as referenced above shall be limited to:

a) Acquired Immune Deficiency Syndrome (AIDS) diagnosed patients requiring isolation care;

b) Medically fragile patients under age 21 who require skilled nursing care.

The period of reimbursement in excess of the class ceilings shall not exceed 6 months. A flat rate shall be paid for the specific patients identified, in addition to the average per diem paid to the facility. The flat rate amount for AIDS patients shall include the costs of incremental staffing and isolation supplies, and shall be trended forward each rate semester using the DRI indices used to compute the operating and patient care ceilings. The flat rate payment for Medically fragile patients under age 21 who require skilled